REPORT

of the

ALMSHOUSE COMMISSION

Submitted to

THE GOVERNOR OF MARYLAND

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November 22, 1940

R E P O R T

of the

ALMSHOUSE COMMISSION

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To His Excellency
Herbert R. O'Conor
Governor of the State of Maryland

Dear Sir:

The Almshouse Commission feels that the time has arrived when the present almshouses should be replaced by institutions which are able to furnish adequate medical care to the chronically sick and infirm. The members of the Commission believe that they are reflecting the best thought of many of the people of the State of Maryland who have been interested in the problem of the almshouses over a period of years when they make the recommendations necessary to accomplish this purpose.

In undertaking the work assigned to it, the Commission found that the problems presented by the almshouses as they now exist in the State have been ably set forth in the various reports of studies and surveys made at the request of the Governor and the Legislature at different times in the past. It was unnecessary for the Commission to initiate any new inquiry in order to have the essential facts upon which to develop a plan which would provide care suitable to the needs of the present almshouse inmates.

A Commission appointed in 1929, and reporting in 1931, found that the almshouses were unsuited to the needs of the persons who seek shelter in them. These findings were reaffirmed by a second Commission which made its report in 1933. The 1933 report, after carefully considering the problem as a whole, stressed the necessity of not treating the

almshouse as an isolated county institution, "but as a closely coordinated part of any county plan for the care of the aged, of mothers and widows, of dependent children, of indigent sick, and of County Out Pensioners."

Both of these reports stated that there were practically no able-bodied workers in the almshouses, making the farms in connection with them an unnecessary part of the care needed by the inmates.

A survey in 1938 showed that conditions in the almshouses had not changed in the five-year interval following the 1933 report. This was particularly of interest in view of the fact that during this period a program of public assistance had been developed which conceivably might have provided care for the almshouse inmates.

The Legislative Council which was established in 1939, therefore, undertook as one of its major considerations the question of the kind of care the State should provide for the persons in the almshouses. In order to have current and detailed knowledge of the situation, the State Department of Public Welfare was requested to make another study of the physical and mental condition of these persons and of the resources which they might have for their care; and to bring up-to-date the financial data and knowledge of the physical plant and equipment of the almshouses. The findings of this study were released as a public document and form the last link in the long chain of careful analyses which has been the basis for the activity of this Commission.

There will be no attempt to summarize the detail of data reported in studies and surveys which have been made. In a broad sense, however, the Commission gave special attention to the following general statement of facts in the planning which it has done.

1) Each survey has shown that the almshouses were caring for many people who were chronically ill or in need of special care

because of physical or mental infirmities. The burden which this imposed upon the persons in charge of the institutions was one for which they were not technically equipped, and to which the physical plant of the institutions was unadapted.

There were fire hazards of a serious nature. Plumbing and sanitary facilities were below minimum standards in many instances. In some of the institutions where there were a number of sick persons there were not enough hot water bottles, bedpans, etc. The matrons in charge of housekeeping frequently did not have the ordinary household conveniences, so that the problem of cooking, washing, etc., was difficult.

All of the surveys showed that for the most part the superintendents, matrons and other helpers were kindly in their treatment of the inmates for whom they were responsible.

2) The study which was made by the State Department of Public Welfare in 1940 took particular note of the fact that the almshouse population had remained almost stationary since 1929, so far as total numbers were concerned. Within this total it was shown there had been considerable movement in and out of the institutions. Their populations, therefore, were constantly replenishing themselves through current admissions. One of the questions which the study tried to answer was what it was that kept people from making other arrangements for themselves.

The broad, general findings of the 1940 study were as follows:

a) In December 1939, the total population of the Eastern and Western Shore almshouses was 556.

b) Approximately one-sixth of these people might possibly receive care outside of an institution. Many of them would find it difficult to make arrangements for themselves, since few had families to whom they could return. Since most of them would have to be supported in one way or another by public assistance, the County Welfare Boards would, in all likelihood, have to participate in some way in this part of the program.

c) Approximately one-sixth more were thought to be in need of care in a mental hospital, at least for a period of observation and treatment. The decision as to who was in need of mental hospital care was made, for the purpose of the study, with the help of the State Commissioner of Mental Hygiene in order that there might be a degree of accuracy of judgment in deciding on individual cases.

d) The remaining two-thirds of the present almshouse population were found to be in need of chronic hospital or infirmary care. This meant that they ought to have more or less

> constant medical supervision. Approximately one-half of these persons were bedridden or practically so, and were in need of constant and expert nursing care and medical attention. Many of the remaining one-half might well be cared for by attendants, supervised by trained nurses. The study pointed out, however, that the selection of persons to receive less constant attention, and perhaps less skilled care, could be made only through careful analysis of each situation by a duly qualified physician.
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> The study found that the people in the almshouses were not merely old people who needed a place in which to spend their declining years, but included many persons who might conceivably be restored to economic usefulness, or to a greater self-sufficiency, if given the proper kind of medical or nursing care. Among the December 1939 population of the almshouses, there were approximately two-fifths who were under 65 years of age, which is the age of eligibility for Old Age Assistance. In terms of numbers, this means that there were 220 persons between the ages of 16 and 65.

The members of the Almshouse Commission gave much time and thought to the understanding of these facts as they would bear upon the recommendations which ought to be made for a program for the State of Maryland. They believed their responsibilities were not only to the inmates of the almshouses, but also to those people of the State who, for humanitarian reasons or for reasons of social economy, desire that the care given in these public institutions be suited to the needs of the individuals receiving it.

In addition to consideration of the facts revealed by the studies, the Almshouse Commission made a visit of inspection to the chronic hospital and infirmary maintained by the City of Baltimore. Letters were written to other states to find out what they were doing about this problem, and a careful attempt was made to learn the best thinking of persons expert in the field. In addition, a member of the Commission found it possible to visit the chronic hospital maintained by the City of New York on Welfare Island, which is probably the best institution of its kind in the country.

A report was made of the type of equipment found in the New York institution, the cost of care, etc.

The members of the Almshouse Commission also gave a great deal of thought to the question of whether the State should now plan to do something about the total problem of chronic illness, of which the almshouse population represents only a small segment. The need for this more inclusive planning had been pointed out by the Commission making its report in 1933 in its recognition that what was done for persons in the almshouses had to be part of a larger, coordinated public welfare program of the State. Consideration was given to the great cost to the State of all chronic illness in terms of persons now receiving general public assistance because of unemployability, and of the large proportion of children receiving Aid to Dependent Children who are eligible because of the physical incapacity of the normal wage earner of the household. It was recognized that there were persons receiving Old Age Assistance who require hospital or infirmary care, but who cannot be given that kind of care because it is not available.

RECOMMENDATIONS BY THE COMMISSION

The Almshouse Commission recommends that provision be made for the erection of chronic hospitals and infirmaries for persons in the State who are in need of medical and nursing care because of chronic illness, or who need custodial care because of conditions which make it difficult or impossible to make other arrangements for them; and who can not pay for such care elsewhere. In speaking of a chronic hospital and infirmary,

the Commission has in mind that there will be an institution with two sections, one of which shall be a chronic hospital and the other an infirmary. The differences which the Commission visualizes between the service to be given in the chronic hospital section and the infirmary section will be clarified in the recommendations which follow.

A. TYPE OF PATIENT TO BE CARED FOR

The Commission is of the opinion that when the State considers its total cost of chronic illness, including the cost in terms of the various forms of public assistance where the wage earner is incapacitated, the constructive value of making available chronic hospital or infirmary care to persons now outside of the almshouse will be apparent. Persons who are chronically ill are not necessarily permanently and incurably unemployable. Many of them may be restored to economic usefulness by the proper kind of medical and nursing care adapted to their physical condition. Each person restored to some degree of employability represents not only a potential economic saving to the State, but also a more useful citizen. Persons who will never be able to work again, but whose physical condition can be improved, will be easier to care for and less of a burden upon their family or the community when they are in better health, and as a result happier individuals.

The Commission therefore recommends that hospital and infirmary care be extended to cover the following types of patients:

a) Persons in need of chronic hospital care who are now in the almshouses or elsewhere who are without financial means to pay for their care and whose physical or mental status is such that they need constant nursing care and regular medical treatment.

Into this group will fall those cases, who because of physical handicap or disease, will require nursing assistance for long periods of time, either as bed

patients or as semi-ambulant patients, and who, in addition, will require close medical supervision and often active treatment. It will include persons who have chronic heart disease, cancer cases, chronic arthritics, disabled paralytics, leg ulcer cases, incontinent patients, etc. The degree of their helplessness and the nature of their disability will require adequate skilled nursing service. Their comfort, if not their cure, will require regular medical care and adequate facilities for certain types of treatment, (drug therapy, physio-therapy, dressing, splinting, tapping, etc). There are definitely hospital cases and not infirmary cases.

The Commission, in stating that one criterion for this type of case is that it will require treatment for a long period of time, wishes to stress the point of view that incurability should not be a criterion for admission to the chronic hospital. Many of the cases which will be admitted will no doubt be incurable, but many cases requiring treatment for many months, or for a year or more, will be admitted where there is possibility of partial or complete rehabilitation by chronic hospital care. At present, no general hospital can afford to undertake such long term treatment and for lack of it many arthritics, occasional cardiacs, occasional paralytics and some types of chronic infections when returned to their homes become incurable or die.

b) Persons in need of infirmary care now in the almshouses or elsewhere, who are without financial means to pay for their care, but whose physical or mental status is chronically such that they require a degree of supervision which would render them unsuitable for boarding homes.

Patients with senile changes will make up a considerable portion of this group. Their physical status is such that, for the most part, they can give themselves necessary personal care (dressing, undressing, going to meals and feeding themselves, washing, bathing, etc.) They do not require active medical treatment, but do require regular medical supervision, since they are subject to many acute ailments and to progressive physical deterioration. Their mental status is such that they require a definite amount of kindly supervision and discipline. There will be a large number of persons who are undergoing senile changes who can be adequately cared for in boarding homes and should not become a part of the infirmary population. The infirmary should be used for those persons, who, either because of their medical needs or because of peculiar or eccentric habits which make it impossible

> for them to live in a home will require facilities which cannot be provided outside of the infirmary.
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> In addition, there will be others less advanced in years, who, because of permanent physical or mental handicaps such as varying degrees of blindness, deafness, mental impairment or crippling, will fall into this same category of those able to give themselves necessary personal care, but requiring periodic medical supervision and minimal nursing care.

The Commission recommends that no patients be admitted to the chronic hospitals and infirmaries who have tuberculosis in a transmissable form, mental disease of the type requiring care in a mental hospital, or an orthopedic disease of a type admissible to the special orthopedic hospitals.

The Commission also recommends that no patient under 16 years of age be admitted to these chronic hospitals and infirmaries. This recommendation grows out of the fact that the character of the patient population will be such that special provision for children having chronic illness should be separately made.

There is full recognition of the fact that the State does not provide adequate facilities for children who have chronic illness at the present time. This is especially true for chronic and sub-acute rheumatic heart disease in childhood. Such children, to attain the maximum degree of recovery from an acute heart infection, often require many months of bed rest, with nursing and medical supervision. This form of prolonged treatment cannot be furnished in general hospitals and frequently cannot be adequately provided in the child's home. There are also children who need a place for convalescence following prolonged illness of many types. The Commission recommends, therefore, that in selecting sites and making architectural plans for the proposed chronic hospitals and infirmaries, consideration be given to the possible future addition of a wing or adjoining

building to be devoted to the care of chronic disease in children.

The Commission recommends that admission to the chronic hospitals and infirmaries be made on the basis of a statement by a physician who, after an examination, finds that the patient is in need of chronic hospital or infirmary care; and of a further statement by the local County Welfare Board that the patient is unable to pay for the cost of his care. The County Commissioners of each county will be responsible for payment of a fixed sum for the care of each patient from their county. Final arrangements for admission shall be made only after the County Commissioners have given their approval.

B. PATIENTS SHALL BE ACCEPTED ONLY IF UNABLE TO PAY FULL COST OF CARE ELSEWHERE

No patient shall be admitted either to the chronic hospital or infirmary section of such institution if he is able to pay the cost of proper hospital care elsewhere.

The Commission recommends that in all cases admitted there shall be collected from the patient or his family as much of the actual cost of the maintenance as it is reasonably possible for either of them to pay. No case, however, shall pay above the actual per diem cost, when that per diem cost is calculated on the basis of total cost of running the institution.

C. NUMBER OF PERSONS LIKELY TO BE IN NEED OF CHRONIC HOSPITAL OR INFIRMARY CARE

The Almshouse Commission spent considerable time discussing how to estimate the number of persons likely to be in need of chronic hospital or infirmary care. The difficulties of such prediction were clear from the beginning.

The figures available from the National Health Survey (1935) gave material on the incidence of chronic illness in the population as a whole.

The Commission recognized, however, that by no means all persons who are chronically ill will be in need of hospital care, and that some who are in need of that care can pay for it. There was also recognition of the fact that there might be a difference in the need for infirmary and chronic hospital care in the rural areas of the State and in Baltimore City.

After much careful consideration, the Commission decided to use data furnished by the Baltimore City Chronic Hospital and Infirmary as the basis for the estimate of the number of beds which would be needed in the counties. In doing this, it was aware of the fact that the Baltimore City institution has a waiting list in its chronic hospital section, for which the figures used make no allowance.

The experience of the Baltimore City Chronic Hospital has been that 2.9 persons per 1,000 population have received care during the past year, and that 25% of these persons have been in the hospital at any given time. The figures for the Baltimore City Infirmary show that during the past year 2.0 persons per 1,000 population have been given care, with 53% of these persons in the infirmary at any given time during the year.

On the basis of these data, and using the preliminary releases from the 1940 census for total population of the counties of the State, an estimate has been made of the number of beds for which it is desirable that provision be made in the proposed institutions. Attention is called to the effect which the longer stay of the infirmary cases has on the ratio of infirmary beds to chronic hospital beds. The average stay of a patient in the chronic hospital was three months. This means that the same bed could be used for four different people during the year. The average stay of a patient in the infirmary, on the other hand, was slightly more than six

months, so the same bed could be counted on to take care of only approximately two infirmary patients during the year.

Number of Beds Likely to be Needed for Chronic Hospital and Infirmary Care (exclusive of Baltimore City

Geographical Area	Total Beds	Chronic Hospital	Infirmary
Western Maryland	320	130	190
Central Maryland	690	280	410
Southern Maryland	350	140	210
Eastern Shore	350	140	210
TOTAL	1,710	690	1,020

Western Maryland - Garrett, Allegany and Washington Counties
Central Maryland - Frederick, Baltimore, Montgomery, Harford, Howard and Carroll Counties
Southern Maryland - Anne Arundel, Charles, Calvert, Prince George's and St. Mary's Counties
Eastern Shore - Cecil, Caroline, Dorchester, Kent, Queen Anne's Somerset, Talbot, Wicomico and Worcester Counties

The Commission recognizes that the above figures are likely to be an underestimate of the need for beds. They include no allowance for the number of persons who cannot pay for their care and who are now in other private and public institutions which give care to persons who are chronically ill in Baltimore City. Neither do they include an allowance to cover the number of persons now on waiting lists and unprovided for.

D. TYPE OF INSTITUTION RECOMMENDED

The Commission recommends that the institutions which are to be built by the State shall meet the modern standards for chronic hospitals and infirmaries, and shall not be designed merely to serve the purpose of rest homes, homes for the aged, or institutions in which the care given is chiefly custodial.

In employing the terms infirmary and chronic hospital, the Commission does not wish to convey the impression that these are to be two separate

institutions which might possibly be located at different places, but rather that each institution will have an infirmary section and a chronic hospital section. This provision of two different kinds of care as part of the same plant will make it easier to transfer patients according to their need, and will also make it unnecessary to duplicate certain basic capital costs.

It has been the judgment of technical experts in the field that small institutions cannot be run as economically as larger ones. This is related to the fact that the cost of increasing the size of the basic plant to provide more facilities at the same location is less than reproducing these basic costs for a number of institutions. The Commission recommends, therefore, that the State build two large institutions for the counties rather than a number of small ones, and that one of these be located on the Eastern Shore and one on the Western Shore of Maryland.

The Commission believes that the exact sites to be selected for these chronic hospitals and infirmaries should be made a matter of careful study at the time of the building of the institutions. There may be a number of different places which could provide the necessary facilities.

The important principle to be observed in the selection of site is that each chronic hospital and infirmary shall be located near a general hospital which has proper equipment and a medical staff of sufficient size to take care of the problems of acute illness for those patients who will come to be in need of general hospital care. It is essential that this principle be observed if the state is to avoid the duplication of certain expensive surgical and diagnostic equipment necessary for a general hospital dealing with acute diseases, and which would not be used sufficiently in the chronic hospital to justify the additional basic cost.

A lower cost per bed is possible in this type of institution as opposed to a general hospital, because of omitting many types of facilities necessary in the latter. It is estimated that the average cost per bed for the recommended institutions will be about $1500, exclusive of site, power plant, water system, sewage, and special hospital equipment, which is less than one-half of the cost per bed in a fully equipped general hospital. More accurate figures must await consultation with architects who have had placed before them a clear description of what is wanted and needed in these institutions.

The Commission recommends that there be consultation with physicians, hospital superintendents and others who have had experience in the field when the detailed specifications for the buildings are considered. Persons with the necessary qualifications and basic experience to advise on this problem are available in the State of Maryland, and would undoubtedly be willing to cooperate in this planning.

Special attention should be given to the differences between chronic hospital and general hospital care which will affect the architectural plan. The chronic hospitals, for instance, will need more homelike surroundings than a general hospital because of the much longer period of time the patients will spend within the hospital as a result of the nature of their illness. Other factors of difference also will need to be given consideration.

The Commission recommends that the institutions be so constructed as to make proper provision for both the white and colored races.

The Commission further recommends that the architectural plan of the institutions be such as to make it possible to add units without too great cost as the need for them is demonstrated in the future.

E. SHARING OF COST BETWEEN STATE AND COUNTIES

The Commission recommends that the financial cost of the chronic hospitals and infirmaries be shared by the State and the counties in the following manner:

1) That the State assume the total cost of the buildings and physical plant of the hospitals and infirmaries, and the cost of repair, upkeep, etc.

2) That the counties be required to pay the sum of 75¢ per day for the care of each patient, and that the State make up the difference between this amount and the actual cost of care where such a difference occurs.

The Commission recommends that the charge of 75¢ per day be kept constant for the counties, even though the patient for whom payment is made may spend part of the time in the infirmary section and part of the time in the chronic hospital section of the institution, or is in a general hospital for a short period of time. It seems necessary for the State to assume responsibility for the fluctuations in cost which will occur by reason of transfers between different kinds of care, and thus to facilitate the problems of management in providing care which is continuously adapted to the needs of the patient.

In making the recommendation of 75¢ as the per days' care cost to be charged to the counties, the Commission wishes to point to the fact that the last figures available on cost of care per inmate in the almshouses show a present average expenditure at the rate of 69¢ per day.*

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* This is a combined average for all of the almshouses in the State. For details showing the average cost of care for each almshouse, see Report on the Almshouses in Maryland, 1940.

F. ADMINISTRATIVE RESPONSIBILITY FOR PROPOSED HOSPITALS AND INFIRMARIES

The Commission recommends that responsibility for the administration of the chronic hospitals and infirmaries be centralized in an already existing state department, and that the state department selected be responsible for working out the interrelationships of other state departments and agencies which will be involved in the program. Because of its present relation to the various phases of the public welfare program in the State, including state-aid to private hospitals, it is recommended that authority for administration be centralized in the State Department of Public Welfare. Proper provision will need to be made for the State Department of Public Welfare to employ staff members with the necessary technical background for discharge of this responsibility.

It is recommended that there be a technical Advisory Committee to the State Department of Public Welfare for this phase of its work, composed of the following persons: the superintendent of the Maryland Tuberculosis Sanitorium; the commissioner of Mental Hygiene; the director of the State Department of Health; two physicians appointed by the Medical & Chirurgical Faculty; the superintendent of the University of Maryland Hospital; the director of the Department of Public Welfare of Baltimore City; and two members to be appointed by the Board of Visitors (described in the following paragraph), one from the Eastern Shore and one from the Western Shore.

It is recommended that each of the chronic hospitals and infirmaries shall have a Board of Visitors consisting of one member of the Board of County Commissioners for each county in the area served by the institution. This Board of Visitors shall make suggestions concerning the conduct and maintenance of the chronic hospitals and infirmaries.

G. PROBLEM OF UNMET NEEDS IN BALTIMORE CITY

The Commission has had delivered to it for its consideration a study which has been made by the Council of Social Agencies of Baltimore City showing the extent to which the present need for chronic hospital care of the city exceeds all available facilities. It is apparent from these data that it is going to be necessary to build an addition to the present Baltimore City Chronic Hospital.

The Commission recognizes that Baltimore City has had no financial assistance from the State in meeting its responsibilities with respect to chronic hospital and infirmary care. It recommends that the necessary expansion of physical plant in Baltimore City be aided by the State.

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The Almshouse Commission has had the benefit of the advice of the Committee on Almshouses of the Legislative Council, Members of which have been present at all meetings, of Dr. George H. Preston, Commissioner of Mental Hygiene for the State, and of

Mr. T. J. S. Waxter, Director, Department of Public Welfare of Baltimore City.

Respectfully submitted,

Walter N. Kirkman, Chairman

Dr. Maurice C. Pincoffs, Vice-Chairman

J. Milton Patterson, Secretary

Senator Frank J. Flynn

Harry Greenstein

Frank J. Bender

Dr. E. Paul Knotts

Raymond E. Kennedy

Julius E. Schindler

Mrs. O. Harold Williamson

Mrs. Louis N. Phipps

Mrs. George V. Lottier